	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155757	B. WIN			03/01/	2013
NAME OF P	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		•			OSEGATE DR		
ROSEGA	TE VILLAGE			INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000000							
	This wisit was f	an a Dagartification and	F00	0000			
		or a Recertification and	F00	0000	Rosegate Village respectfully	on	
	State Licensure	e Survey.			requests desk review in lieu of an onsite visit.		
	Survey dates:	February 25, 26, 27,					
	28, and March						
	Facility number	r: 011149					
	Provider number						
	AIM number: 2	00829340					
	Survey Team:						
	Leia Alley, RN-	TC:					
	Patty Allen, BS						
	Marcy Smith, R						
	Dinah Jones, R						
	Billail bolles, i	VI V					
	Census Bed Ty	/pe:					
	SNF: 38						
	SNF/NF: 105						
	Total: 143						
	Census Payor	Type:					
	Medicare: 37						
	Medicaid: 75						
	Other: 31						
	Total: 143						
	-						
	These deficiend	cies reflect state					
	findings cited in	n accordance with 410					
	IAC 16.2.						
	Quality Review	completed on March					
	•	mberly Perigo, RN.					
	• •						
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURI	Ξ	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CO A. BUILDING B. WING	00					
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP COD OSEGATE DR	Е				
ROSEGA	TE VILLAGE	INDIANAPOLIS, IN 46237						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HZQT11

Facility ID: 011149

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155757	B. WING		03/01/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	1		OSEGATE DR	
POSEGN	TE VILLAGE			IAPOLIS, IN 46237	
NOOLOA	TIL VILLAGE		INDIAN		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000279	483.20(d), 483.20				
SS=D		PREHENSIVE CARE			
	PLANS				
		e the results of the			
		evelop, review and revise			
	the resident's con	nprehensive plan of care.			
	The facility must (develop a comprehensive			
	•	n resident that includes			
		ctives and timetables to			
	•	medical, nursing, and			
		nosocial needs that are			
	identified in the co	omprehensive assessment.			
	•	st describe the services			
		nished to attain or maintain			
		hest practicable physical,			
		hosocial well-being as			
		183.25; and any services vise be required under			
		not provided due to the			
	-	e of rights under §483.10,			
		t to refuse treatment under			
	§483.10(b)(4).	t to relace treatment ander			
	Based on recor	rd review and	F000279	F279	03/25/2013
		acility failed to develop		What corrective action(s) will be	33,20,2013
		ve care plan for 1 of 5		accomplished for those residents	
	•	•		found to have been affected by the	
	•	iving anti-coagulant		deficient practice?	
		a sample of 10		Resident #73 had a	
		wed for unnecessary		comprehensive care plan developed	
	medications. (F	Resident #73.)		for receiving anti-coagulant	
				medications.	
	Findings includ	le:		How will you identify other	
	J			residents having the potential to be	.
	A clinical record	d review on 2/28/13 at		affected by the same deficient	
		cated a comprehensive		practice and what corrective action	
	•	•		will be taken?	
	. ,	statement of the goals		· A chart audit identified	
	•	of the nursing care		residents who receive anti-coagulan	t
	provided to the	patient and the		medications.	
			1	l .	

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Event ID: HZQT11

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If continuation sheet Page 3 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		155757	B. WIN			03/01/2	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R					
DOSEC A	ATE VIII ACE				OSEGATE DR APOLIS, IN 46237		
RUSEGA	ATE VILLAGE			INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	interventions r	equired to accomplish			· Residents with anti-coagular	nt	
	the plan) had i	not been initiated for			medications had a comprehensive		
		who was receiving the			care plan developed for receiving		
		medication, warfarin.			anti-coagulant medications.		
					What measures will be put into		
		diagnoses included,			place or what systemic changes you	ı	
		mited to: acute			will make to ensure that the		
		p vein thrombosis			deficient practice does not recur?		
	[blood clot] to	her lower extremity			· The Director of Nursing		
	[leg], atrial fibr	illation [irregular			Services (DNS) reviewed the policies	;	
	heartbeat], and	d congestive heart			on developing comprehensive care		
	failure.	o			plans focused on anti-coagulant		
	Tanaro.				medications.		
	The Director o	f Nursing indicated in			· Nursing staff, MDS		
		f Nursing indicated, in			Coordinator, and MDS Assistants		
		n 3/1/13 at 11:00 a.m.,			were inserviced on or before		
	a comprehens	ive care plan had not			3/25/13 by the DNS on developing		
	been initiated	for Resident #73, for			temporary and permanent		
	the anti-coagu	lant medication,			comprehensive care plans for		
	warfarin.				residents receiving anti-coagulant		
					medications		
	3.1-35(a)				· On all new admissions		
	0.1 00(a)				nursing staff will develop a		
					temporary care plan for residents		
					receiving anti-coagulant medication		
					until the permanent comprehensive	!	
					care plan is developed.		
					· IDT team will ensure care		
					plan is developed when a resident is		
					receiving anti-coagulant medication	•	
					· Residents receiving		
					anti-coagulant medications will be		
					reviewed no less than quarterly		
					and/or with significant change by		
					nurse managers to ensure the comprehensive care plan is		
					developed for receiving		
					anti-coagulant medications.		
					anti-coaguiant medications.		

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PRINTED: 03/20/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155757	A. BUILDING B. WING	00	COMPLETED 03/01/2013
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
ROSEGA	TE VILLAGE			OSEGATE DR APOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS/Qualified Designee is responsible for the completion of the Coumadin Therapy Continuous Quality Improvement (CQI) audit tool for residents who receive anti-coagulant medications one unit per day for four weeks, monthly for two months, then quarterly thereafter for at least six months with results reported to the CQI committee overseen by the executive director. If threshold is not achieved of 95% an action plan may be developed to ensure compliance.	

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Event ID: HZQT11

Facility ID: 011149

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STATEMEN	T OF DEFICIENCIES						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155757	B. WINC	ì		03/01/	2013
	ROVIDER OR SUPPLIER			7510 RC	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F000329 SS=D	from unnecessary drug is any drug of dose (including dose (including dose (including dose) are side of the administration and freedom of the consequences where offered to the administration and the content of the con	DRUGS rug regimen must be free y drugs. An unnecessary when used in excessive uplicate therapy); or for n; or without adequate hout adequate indications ne presence of adverse nich indicate the dose d or discontinued; or any he reasons above. Therefore the discontinued and the continued and the continued and the clinical record; and the antipsychotic drugs ose reductions, and entions, unless clinically in an effort to discontinue	F000	0329	F329 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #155 currently does not currently reside at the facility. Resident #112 has non-medication interventions offered and documented prior to administration of anti-anxiety medication. How will you identify other residents having the potential to be affected by the same deficient	s	03/25/2013

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Event ID: HZQT11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLI	ETED
		155757	B. WIN			03/01/2	2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			OSEGATE DR		
ROSEGA	ATE VILLAGE				IAPOLIS, IN 46237		
					T	-	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
	Findings includ	ie:			practice and what corrective action	'	
					will be taken? A chart audit identified		
	1)				residents who require as needed		
		cord of Resident #155			(PRN) anti-anxiety medication.		
	was reviewed	on 2/28/11 at 11:00			· Residents with PRN		
	a.m.				anti-anxiety medication will be		
					offered non-pharmacological		
	Diagnoses for	Resident #155			interventions as directed per		
	1	ere not limited to			individualized plan of care and		
	· ·	ronic obstructive			documented effectiveness. If		
	pulmonary dise				non-pharmacological interventions		
		3400.			are not effective PRN anti-anxiety		
	An admission I	Minimum Data Set			medication may be given per		
					physician with the effectiveness of		
	· ·	ated 2/19/13, indicated			the medication documented.		
		was independent with			Nursing staff was inserviced		
	his decision ma	akıng skills.			on or before 3/25/13 by the DNS		
					and Social Services on residents wit	n	
		order, dated 2/20/13,			PRN anti-anxiety medication being offered non-pharmacological		
	indicated Resid	dent #155 could			interventions as directed per		
	receive Ativan	(an anti-anxiety			individualized plan of care and		
	medication), 0.	5 milligrams (mg)			documenting the effectiveness. If		
	every 8 hours,	as needed, for anxiety.			non-pharmacological interventions		
					are not effective PRN anti-anxiety		
	A care plan, da	ated 2/22/13, indicated			medication may be given per		
	l ' '	esident #155 being at			physician order with the		
		and symptoms of			effectiveness of the medication		
	_	entions included,			documented.		
		1 during acute phase					
		emands on resident.			What measures will be put into		
	Remove from				place or what systemic changes you	u	
					will make to ensure that the		
	stimulationIn				deficient practice does not recur? The Director of Nursing		
		dications as ordered for			Services (DNS) reviewed the policies	,	
	1	edicationsIntervention			on Medication Administration.	,	
	_	resident to voice			Nursing staff was inserviced		
	feelings/frustra	tions/concerns and					

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If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURV	/EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPLETED)
		155757	B. WIN			03/01/201	3
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8			OSEGATE DR		
ROSEGA	TE VILLAGE				APOLIS, IN 46237		
	TE VILLAGE						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
	address as app	oropriate"			on the Behavior Management Policy		
					and Procedure on or before 3/25/13	3	
	A Medication A	Administration Record			by the DNS and Social Services on		
	(MAR) for Febr	ruary, 2013, indicated			residents with PRN anti-anxiety		
	, ,	received Ativan, 0.5			medication being offered		
		2/24, and 2/26, 2013.			non-pharmacological interventions		
		nentation on the back of			as directed per individualized plan o	†	
					care and documenting the		
		ated on 2/21/13 he			effectiveness. If		
		n for complaints of			non-pharmacological interventions are not effective PRN anti-anxiety		
	,	t was effective and on			medication may be given with the		
	2/24/13 he rec	eived Ativan for			effectiveness of the medication		
	"nerves" and it	was effective. No			documented.		
	documentation	was found in regards			· Will request from physician		
	to the administ	ration of Ativan on			that the duration of the PRN		
	2/26/13.				Anti-anxiety medications not to		
	2/20/10:				exceed seven days.		
	No documenta	tion was found in			Behavior management team		
					will review non-pharmacological		
		's record to indicate the			interventions for residents requiring		
		nxiety was assessed or			PRN anti-anxiety medications and		
	·	n-pharmacological			will included them on our behavior		
	methods were	attempted prior to			monitoring flow sheets.		
	administering t	he as needed			· Any new order for PRN		
	anti-anxiety me	edication.			anti-anxiety medications usage is		
					reviewed no less than weekly by		
					nurse managers for necessity and		
	During an inter	view with the DON on			appropriateness of continued use.		
	_		1		How the corrective action(s) will be		
		5 p.m., she indicated			monitored to ensure the deficient		
	anxiety sympto				practice will not recur, i.e., what		
		ause and severity, and	1		quality assurance program will be		
	-	logical interventions			put into place?		
	should be cons	sidered, prior to			· The DNS/Qualified Designee		
	administering a	as needed anxiety	1		is responsible for the completion of		
	_	ne indicated the facility			the Unnecessary Medication audit		
		policy regarding			tool for non- pharmacological		
	offering non-ph	. , , ,			interventions for one unit per day		
	oneing non-pr	iaimacological					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155757	B. WIN			03/01/	2013
NAME OF P	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
DOOFOA	TE VIII A OE				OSEGATE DR		
RUSEGA	ATE VILLAGE			INDIAN	APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		or to administering			for four weeks, monthly for two months, then quarterly thereafter		
	,	edications. She			for at least six months with results		
	start inservices	need to do this. I will			reported to the Continuous Quality		
	Start inservices	s now.			Improvement (CQI) committee		
					overseen by the executive director.		
					If threshold of 95% is not achieved		
					an action plan may be developed to ensure compliance.		
					ensure compnance.		
	2)						
	The clinical red	ord for Resident #112					
	was reviewed	on 2/27/12 at 3:15 p.m.					
	Diagnoses for	Resident #112					
	included but w	ere not limited to acute					
	hypoxia (lack c	of oxygen), respiratory					
	failure, and an	xiety.					
	A physicians o						
	· · · · · · · · · · · · · · · · · · ·	ated Resident #112					
	could have "At	ivan 0.5 mg, 1 tablet by					
	•	x hours as needed for					
	anxiety."						
		n Administration					
	` ,	indicated Resident					
		the medication on					
		0/12, and 1/14/13. The					
		d the medication was					
	_	crease of anxiety, but					
		information in regards					
		Resident #112's					
	anxiety or if an	y alternative measures					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			NSTRUCTION 00	(X3) DATE : COMPL			
		155757		LDING		03/01/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	I.	
NAME OF P	ROVIDER OR SUPPLIER				DSEGATE DR		
ROSEGA	TE VILLAGE			INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	had been offer	ea.					
	10:00 a.m., wit Nursing Servic was no further regards to inter giving the med An untitled faci 7/20/11, receiv Nursing (DON) p.m., indicated assessment of symptoms prio	lity policy, dated ed from the Director of on 2/28/13 at 3:25					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155757	B. WING		03/01/2013
NAME OF P	DOWNED OF CLIDAL ICA		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		7510 R	ROSEGATE DR	
	TE VILLAGE			NAPOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000364	483.35(d)(1)-(2)	IE/ADDEAD			
SS=D	NUTRITIVE VALI PALATABLE/PRE				
		ceives and the facility			
		pared by methods that			
		value, flavor, and			
		food that is palatable,			
		the proper temperature.			
		view and observation,	F000364	F364	03/25/2013
	_	d to provide residents		What corrective action(s) will be	
	with food meet	ing their taste		accomplished for those residents	
	requirements for	or palatability for 4 of		found to have been affected by the	
	19 residents in	terviewed. This had		deficient practice?	
	the potential to	affect 10 of 10		Resident #186 registered dietician interviewed resident on	
	residents who i	received noon meal		food temperatures. Residents	
	room travs fron	n the kitchen in the		stated they are now receiving all ho	,
	_	on of 143. (Residents		and cold food items meeting their	
	#13, #63, #186	•		taste requirements for palatability a	at
	, ,	,		the time the resident receives their	
	Findings includ	le·		room tray.	
	i mamgo molaa			· Resident #283 supervisor	
	On 02/26/13 at	: 10:00 a.m., an		interviewed resident on food likes	
		Resident #186, they		and dislikes related to food	
		·		temperatures. Interview was	
		oom trays were cold.		documented in chart and updated on tray card and care plan.	
		is not as good when it		Resident#63 supervisor	
		ed hot, but was served		interviewed resident on food likes	
	cold.			and dislikes related to food	
	0 00/00/40 :	0.00		temperatures. Interview was	
		9:00 a.m, during an		documented in chart and updated	
		Resident #283, they		on tray card and care plan.	
		oom trays were cold.		· Resident #13 supervisor	
		is not as good when it		interviewed resident on food likes	
	should be serve	ed hot, but was served		and dislikes related to food	
	cold.			temperatures. Interview was	
				documented in chart and updated	
	On 02/26/13 at	: 10:00 a.m., during an		on tray card and care plan.	
				Plate warmer is turned on to	⁰

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPLE	TED
		155757		LDING		03/01/2	.013
			B. WIN		ADDRESS SITY STATE ZIR CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
50050					OSEGATE DR		
ROSEGA	ATE VILLAGE			INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	DATE
	interview with I	Resident #63, they			ensure hot food is served at a		
		oom trays were cold.			palatability temperature		
		r is not as good when it			· Replaced heat on demand		
		•			trays.		
		red hot, but was served					
	cold.						
					How will you identify other		
	On 02/26/13 a	t 3:00 p.m., during an			residents having the potential to b	e	
	interview with I	Resident #13, they			affected by the same deficient		
	indicated the re	oom trays were cold.			practice and what corrective action	n	
		r is not as good when it			will be taken?		
		ed hot, but was served			· All residents who receive		
		ed flot, but was served			room trays have the potential to be	2	
	cold.				affected. A facility audit identified		
					residents who receive room trays.		
	On 02/26/13 a	t 12:20 p.m., food on			· Residents who receive roo	m	
	the steam table	e was measured for			trays will be served all hot and cold		
	temperature.	The sour kraut			food items meeting their taste		
	measured 140	degrees Fahrenheit,			requirements for palatability at the		
		es 150 degrees			time the resident receives the food		
	•	d smoked sausage 150			· Plate warmer is turned on t	О	
		nheit. The room tray			ensure hot food is served at a		
	_	•			palatability temperature		
		chen at 12:40 p.m., and			· Replaced heat on demand		
	1	were served at 12:48			trays.		
	p.m. At 12:50	p.m., the temperatures			· Dietary staff was inserviced		
	of the food on	the test tray were			on or before 3/25/13 by the dietary	<i>'</i>	
	measured. Th	e sauerkraut measured			services manager on the proper use	9	
	112 degrees F	ahrenheit, mashed			of the plate warmer, heat on		
	_	legrees Fahrenheit,			demand system and on food		
	l '	ausage 120 degrees			temperature requirements.		
		ausage 120 degrees			What measures will be put into		
	Fahrenheit.				place or what systemic changes yo	u	
					will make to ensure that the		
	On 02/26/13 a	t 1:00 p.m., during an			deficient practice does not recur?		
	interview with t	the dietary manger,			· Identified plate warmer was	S	
			1		not turned on.		
	assistance ma	nger and consultant				I	
	assistance ma dietitian, they i	nger and consultant ndicated the			Assigned dietary aide to tur plate warmer on 1 hour prior to	n	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	OVIDER/SUPPLIER/CLIA (X2) MI		2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		UILDING 00		COMPLETED		
		155757		WING		03/01/2013		
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	₹						
ROSEGATE VILLAGE			7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
KUSEGF	TE VILLAGE			INDIAN	IAPOLIS, IN 40237			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	RRECTION (X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG				TAG	DEFICIENCY)	DATE		
	and the food was cold. They understood some of the residents complained and they accepted the				meal service.			
					· Dietary supervisor/designee			
					will ensure plate warmer is turned			
					on.			
	validity of their	complaints.			The Executive Director (ED)			
					reviewed the dietary policies on			
	On 02/27/13 at 9:00 a.m., the consultant dietitian indicated the staff				proper food temperatures with the			
					dietary services manager.			
	had been turning off the plate warmer		· Dietary staff was inserviced					
		reason for the low			on or before 3/25/13 by the dietary			
	temperatures a				services manager on the proper use			
	l temperatures a	and cold lood.			of the plate warmer, heat on			
					demand system and on food			
		t 4:00 p.m., the facility			temperature requirements.			
	Administrator i	ndicated he agreed			· When staff delivers room			
	with the consul	Itant dietitian and			tray to resident they will ask them it	f		
	dietary manage	er that the low			all hot and cold food items meet			
		and cold food on the			their taste requirements for			
		the result of staff			palatability they will get them a			
	•				replacement tray that meets their			
	turning off the plate warmer.				preferences.			
					· Customer Care			
	3.1-21(a)(2)				representatives will interview			
					residents during customer care			
					rounds regarding all hot and cold			
					food items meeting their taste			
					requirements for palatability at the			
					time the resident receives their			
					room tray.			
					How the corrective action(s) will be	,		
					monitored to ensure the deficient			
					practice will not recur, i.e., what			
					quality assurance program will be			
					put into place?			
					The Executive Director			
					/Qualified Designee are responsible			
					for the completion of the			
					Temperature Monitoring audit tool			
					for residents who receive a room			

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/01/2013			
	ROVIDER OR SUPPLIER TE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
	SUMMARY STATEMENT OF DEFICIENCIES	ID	AFOLIS, IN 40237	(X5)			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				
			tray. One room tray will be tested daily during a scheduled meal service for four weeks, monthly fo two months, then quarterly thereafter for at least six months with results reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If threshold of 95% is not achieved an action plan may be developed to ensure compliance.	r			

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Event ID: HZQT11

Facility ID: 011149

If continuation sheet

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